THE EFFECTIVENESS OF THE REFERRAL SYSTEM IN PRIMARY HEALTH CARE IN THE WEST RAND REGION: A NORMATIVE-ETHICAL STUDY WITH SPECIAL EMPHASIS ON TRADITIONAL HEALERS

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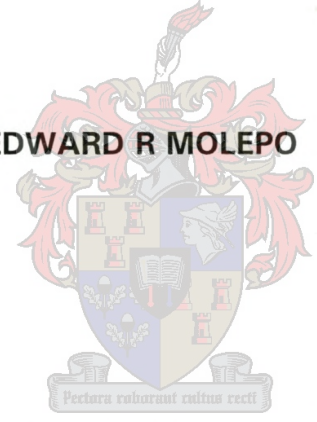

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DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature:

Date:

ABSTRACT

The aim of this research is to identify the various levels of health care units, their relationships and the problems hindering an effective referral system. To achieve this goal, use is made of a case study of the West Rand area in Gauteng. The standpoint is that, to achieve Primary Health for all South Africans referral systems within health care units and levels must be reciprocal. It is argued that for Primary Health Care to be successful, it must satisfy the goal of affordability appropriateness and accessibility. Results from the research revealed that four health care levels, namely traditional healers, health NGOs, Clinics, and Hospitals. Though there is some degree of referral in the study area, it was observed that referrals in the study area were not reciprocal. Amongst the major problems identified as hindering an effective referral system in the study area, include lack of cooperation between health institutions, poor health infrastructure and communication network as well as lack of other health paraphernalia. The research also found that government policy towards some of the health institutions (Traditional healers) contributes to the inefficiency of proper referrals in the study area.

OPSOMMING

Die oogmerk van hierdie ondersoek is om die verskillende vlakke van gesondheidsorgeenhede, hul onderlinge verbande en die probleme wat doeltreffende verwysings in die wiele ry, te identifiseer. Dit word gedoen aan die hand van 'n gevallestudie van die Wes-Rand area in Gauteng. Die uitgangspunt is dat doeltreffende Primêre Gesondheid vir alle Suid-Afrikaners afhang van resiprokale verwysingsisteme tussen gesondheidsorgeenhede en –vlakke. Suksesvolle Primêre Gesondheidsorg vereis bekostigbaarheid, toepaslikheid en toeganklikheid. Die ondersoek het vier gesondheidsorgvlakke aan die lig gebring: tradisionele genesers, gesondheids-nie-regerings-organisasies, klinieke en hospitale. Hoewel daar 'n mate van onderlinge verwysing in die studie-area bestaan, was dit nie wederkerig nie. Onder die vernaamste struikelblokke vir 'n doeltreffende verwysingsisteem tel swak samewerking tussen gesondheidsinstellings, gebrekkige gesondheidsinfrastruktuur en kommunikasienetwerk, en 'n skaarste aan ander gesondheidsmiddelle. Die ondersoek het ook bevind dat regeringsbeleid aangaande sommige van die gesondheidsinstellings (tradisionele genesers) bydra tot die ondoeltreffendheid van verwysings in die studie-area.

Financial assistance by the National Research Foundation is hereby acknowledged. Opinions expressed in this assignment or conclusions made, are those of the author and are not necessarily those of the National Research Foundation.

DEDICATION

This project is dedicated to the following people:

- To my beloved wife, Mrs Nono Linah Molepo for her support, encouragement, patience, and understanding throughout the study.
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CHAPTER 1

1.0.1: INTRODUCTION

1.1.1: DEFINITION OF P.H.C.

In a comprehensive health programme, primary health care has been defined as non-hospital care, where the primary health care worker may be a doctor, a nurse or even a lay worker. The primary health care worker is the first person approached for help by any individual with a problem. P.H.C. is therefore, first contact care and constitutes an individual point of entry (Volk: 1980: 170-172).

1.1.2: A HISTORICAL BACKGROUND (Traditional healers)

Historically, traditional healers were the conservers of health care. Community as well as tribal authorities had high respect for the traditional healers. A traditional healer and Traditional Medical Practice, according to the W.H.O. are defined as: someone who is recognized by the community in which he lives as competent to provide health care, using vegetables, animals and mineral substances and certain other methods based on social, cultural and religious background, as well as prevailing knowledge, attitude and beliefs regarding physical, mental and social well-being and the curation of diseases and disabilities in the community (Van Rensburg *et al* 1992: 332-333).

Traditional healers were associated with the science and the art of preventing diseases, prolonging life, promoting physical and mental health, control of community infection, organization of health services for early diagnosis and preventive treatment of diseases and the development of social machinery which ensures that every individual in the community has an adequate standard of living for the maintenance of health.

Traditional healers do not all perform the same functions nor do they belong to the same category. Each has his own province and specializes in a particular area, and the technique employed also differs. Each command and own a particular method of diagnosis and his own particular kind of medicine. Blacks and whites in South Africa, furthermore have a choice between different categories of indigenous healers, namely diviners and herbalists. Diviners concentrate on the diagnosis of mysteries. They analyze the causes of specific events and interpret the message of the ancestral spirits. They use divine powers and explain the unknown, and also provide medication where necessary.

Herbalists are ordinary people who have acquired an extensive knowledge of magical techniques and do not typically possess occult power. They are expected to diagnose and to prescribe medication for ordinary ailments and diseases, prevent and alleviate misfortune and disaster, and to promote good fortune and happiness in the community. In fact, they are expected to render assistance in virtually all situations over which people have no control. Some traditional healers with different specialities include sky gods, the rain doctor, the faith healer and prophets.

Before the Europeans colonized South Africa, traditional medicine, intertwined with magic and religion, exerted great political influence on public and private affairs. With the arrival of missionaries in Africa it was thought that Africa could be won over to the Christian faith by teaching them that the western health care was superior to their indigenous traditional care system. All traditional healers were regarded to be witch doctors who exploited the ignorance and superstitiousness of the unenlightened natives. This brought about new values, preferences and behavioral patterns and eventually led to the dismantling of Africa's traditional cosmology and culture (Van Rensburg *et al*: 1992:320-328).

Despite this, traditional care survived in South Africa and has up to the present continued to exist alongside an established health care system in both rural and

urban areas where western culture and medicine are so much more intensely in fashion or in vogue. Traditional healers in South Africa acted like health controllers in the past, controlling both exogenous and endogenous disease. TB patients, for example, were physically separated from others when it occurs in an area so as to prevent direct or indirect contraction of the disease.

1.1.3: P.H.C. DURING APARTHEID SOUTH AFRICA

During the apartheid regime, health services were planned for the community without consultations. Services did not meet their needs, especially of black communities. Whites communities enjoyed more privileges as they were within walking distance or driving distance from health service (ANC: 1994: 7).

It has been observed that there were fragmentation and duplication of health services. Local authorities for example were providing only preventive service, while at the provincial level mainly curative service were provided. Services were not accessible and affordable to black communities. They were not planned according to the community's needs (ANC: 1994: 7).

It should be noted here that P.H.C. is neither a cheaper nor simpler approach to the delivery of health cares, nor is it simply basic health interventions. It is a concept, which is changing the medical culture. Previously this was centered on health professionals where the communities were passive recipients of health services, while the health professionals were the dispensers of health (Van Rooyen: 1994; ANC: 1994: 21). The challenges will inevitably bring about some radical transformations, not only for health services, and of training and research institutions, but also the attitudes of both those providing health services and those demanding health care services. The department of health therefore suggests that the key to health for all in South Africa is a National Development Strategy that incorporates P.H.C. (ANC: 1994: 19).

1.2.1: PRIMARY HEALTH CARE IN POST APARTHIED SOUTH AFRICA

The challenges, which faced the South African health system after the 1994 elections, were to redress social and economic injustices and inequalities, which were present in the country. It is stated that everyone in SA has the right to achieve optimal health care, and it is the responsibility of the state to provide the conditions necessary to achieve it (NPPHC Network: 1998). Health for all South Africans can only be secured and improved by the achievement of an equitable social and economic development through increased levels of employment, standard of education, and the provision of clean water and sanitation (Van Rooyen: 1994: 141; Dennell *et al*: 1995: 37-46).

According to the Reconstruction and Development Plan (RDP) of the new government the national health system must be driven by a P.H.C. approach (ANC: 1994:20). It embodies the concept of community development, and is based on full community participation in planning, provision, control and monitoring of service. It aims to reduce inequalities, and increase accessibility to health services especially in the rural areas and socio-economically deprived communities of South Africa. This approach requires a political will on the part of government and commitment from communities, health-allied workers, health policy makers, and health managers. The primary health care approach therefore is the underlying philosophy for the restructuring of South Africa's health system. It embodies the concept of community development and is based on full community participation in planning, control and monitoring of services (Van Rooyen: 1994: 141; Dennell *et al:* 1995: 37-46).

The South African government, through its adoption of the Reconstruction and Development Programme (RDP) in 1994 committed itself to the development of a district health system based on P.H.C. approach as stated at the Alma-Ata meeting in 1978. It was stated that "P.H.C. is essential health care based on the

scientifically sound and socially acceptable method and technology made universally accessible to individual and family in the community through their full participation and cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination" (Van Rooyen: 1994: 142). Every individual therefore has a right to essential health care services as declared by the Alma-Ata conference in 1978.

1.2.2: P.H.C. IN THE SOUTH AFRICAN CONTEXT

In South Africa, primary health care aims to provide community education around the prevailing health problems along with the methods of preventing and controlling them. Formulated in specific terms, the aims are:

-To promote the provision of food and proper nutrition.

-To ensure adequate supply of safe water and basic sanitation.

-To ensure the provision of maternal and child health services including family planing.

-To prevent and control local endemic diseases.

-To ensure the provision of essential medicine. P.H.C. forms an integral part of the country's national health system, of which it is the central focus, while the P.H.C. approach guides the overall social and economic development of the community (Mukhola *et al*: 1987: 5).

1.2.3: NATIONAL HEALTH SYSTEM

The goal of National Health Care is to make sure that P.H.C. service is available to all permanent residents in South Africa without any form of discrimination. That is, building and strengthening the existing public sector health care system, to fit in with, and strengthen the new district based health care system. Also, it should be based on a comprehensive primary health care approach, and should look after the needs of the whole population in the district, work with and add to the health services provided at all levels.

Finally, the National Health Care system should encourage co-operation of the public and private sectors, so that health care workers, health equipment and buildings are shared between the private and the public sectors. It should also allow persons to use the private health service if they choose to, and if they are prepared to pay for the extra services (Broomberg and Shisana: 1995: 4; ANC: 1994: 19).

It is observed that in a good P.H.C. system, every person in a district should be able to obtain health care from professionally trained health care workers. The primary health system includes a wide range of such workers including primary health care nurse, midwives, social workers and medical doctors. It is therefore clear that not every health care problem needs to be seen by doctors. Health care workers should therefore function as a team co-operating with each other in the delivery of health care services in the most cost effective and appropriate way (Van Rooyen: 1994:144).

The range of services offered by P.H.C. workers are also very extensive, and form the nucleus of a comprehensive health system supported by an effective referral system (cooperation between higher and lower health care levels), and the consultation at secondary and tertiary level. This secondary and tertiary health care must be maintained in order to ensure the smooth functioning of primary health care (Van Rooyen 1994: 144).

1.2.4: HEALTH CARE LEVELS: LINKAGE AND IMPORTANCE OF P.H.C. IN SOUTH AFRICA

A detailed study of health organograms in South Africa reflects the structure and functions of the health services at all levels. Seen from a normative point of view these levels, from the biggest hospital in terms of infrastructure and specialist personnel to the smallest traditional healer, must work in collaboration with one another to achieve good health for all. Accordingly, health care structures should be designed to promote teamwork, including both primary and hospital care.

Thus the continuum of health care from the primary to the tertiary levels will be ensured (Broomberg and Shisana: 1995: 1-11).

The National Health System per definition includes both the public and private health sectors, and should work closely together to improve health services for all South Africans. The private doctor and other private health workers are therefore encouraged to work more closely with the government. This does not mean that they will become government employees but that a relationship of cooperation would be established that benefits both the private health care sector and the public health care sector (Broomberg and Shisana: 1995: 3).

In the new National Health System (N.H.S.), all people living permanently in South Africa will be entitled to treatment whenever they need health care regardless of their ability to pay. Consequently, primary health care in South Africa is affordable (at a level of health care which the community and authorities can afford), though not accessible, that is the continuing and organized supply of an equitable level of health care which is within reach for all South Africans. The accessibility of essential health care services in South Africa therefore becomes an important research question (Broomberg and Shisana: 1995: 3). Inaccessibility to essential health care in South Africa is as a result of geographical (distance, travel time and means of transportation), financial (inability to pay), and functional (appropriateness of health care) inaccessibility.

It is observed that a just distribution of health care is based on the principle of needs, which seeks to achieve equality of opportunity, required by justice (Beauchamp and Childress: 1989: 269-270).

1.3: RESEARCH AIMS AND OBJECTIVES

Though health policy in South Africa is framed with the good intention of providing health to all South Africans, its implementation is problematic. As a result, this work aims at investigating the referral system as a tool for effective

primary health care in the West Rand Region. The specific objectives of this research are:

- To identify and evaluate the various levels of health care units and their relationship
-To identify problems hindering an effective referral system, and to make recommendations to overcome them.

1.4: RESEARCH METHODOLOGY

Various research techniques were implemented in the collection of the research data. First informal interviews were conducted with all the traditional healers in the study area. Visits were made to the hospitals, clinics, and health NGOs in the West Rand area, and the workers were interviewed on aspects relating to the aim and objectives of this study. Secondly, formal interviews using well-structured questionnaires (see Appendix 1) were also administered. These questionnaires were analysed using simple statistical means to come out with percentages needed for conclusions. Lastly, I have also made careful observations during my many rounds of visits I have planned for the study area. From these observations I was able to understand what is actually happening in the field of my research and these observations also helped me to draw conclusions.

1.5: JUSTIFICATION OF STUDY

For P.H.C. to be successful it must satisfy the goal of affordability, appropriateness and accessibility to all South Africans. This goal can only be achieved through an effective referral system. This referral system is one where lower levels of health care units collaborate with higher levels of health care units. This involves lower health care units to not only refer cases to higher health units, but must also receive cases and feedback from higher levels.

Today in South Africa, patients that require further treatment, which is not available at primary health care level, will be referred to a specialist at another

level (large hospitals). If patients bypass the primary care center and go directly to a big hospital, they will be charged a fee, except in cases of emergency and/or if the primary health care centers are closed. The main reason is to foster a good referral system amongst different levels of health, and to discourage unnecessary use of large hospitals that are expensive. The research aim is therefore to investigate the effectiveness of referral systems in the study area and the advantages derived from it. This is important if we consider that it costs about R30 to care for a patient at the clinic as compared to R70 for the same problem at an outpatient department of a regional hospital and nearly R120 at a teaching hospital. Hence to lower the cost for all South Africans, extra charges must be levied on people who skip primary health care centers and go directly to out-patient departments of large hospitals (Broomberg and Shisana: 1995: 4).

An effective referral system in the study area will help to achieve and bring about good health for all South Africans. Finally the identification of problems affecting effective referral systems in South Africa might act as an eye opener for other regions of the country, and even encourage the government to improve implementation of health policies throughout the country.

CHAPTER 2

LITERATURE REVIEW

2.0.1: INTRODUCTION

This study is geared towards investigating referrals systems as an effective tool towards successful Primary Health Care (P.H.C.) in the West Rand Region. International and South Africa literature will be discussed, looking at the relationship between health care levels in South Africa. A review of related literature by prominent researchers has shown that it is accepted that inequality of medical care is inevitable, and the best that can be accomplished is a reduction of the inequality to acceptable limits, and that even the modest goal can only be achieved with a disciplined structure and well organized system (Stephen: 1980: 80). It is also stated that an important principal in the primary health care approach is accountability to community structures at local, district, provincial and national levels. This can only be achieved if there is an effective referral system within these levels (ANC: 1994: 21). In this chapter I will elaborate on these general points of departure. In my conclusion to this chapter, I will summarize the normative principles and ethical values that, according to international and national literature should inform an effective referral system in P.H.C.

2.1.1: INTERNATIONAL LITERATURE ON REFERRAL SYSTEMS

One of the most important spin-offs of evaluating referrals system is the fact that information is generated which can be utilized to broaden the perspective of health care workers at all levels, and to improve community health. The key to all well organized systems of primary health care must be the provision of suitably trained individuals in health positions, and with the right facilities. It is important to evaluate and thereby improve the effectiveness of Primary Health Care, since

decisions made at these levels have a crucial effect on the quality and quantity of services provided.

According to a study done by Fry (1980) there are six major requirements needed for any system of primary health care to be efficient. The services must be accessible to the population served, it must be available when required, must provide the community and family unit with the required basic health care. In addition these services must be supported by an effective referral system so that services outside the scope of primary health care may be provided. Lastly there must be some means of evaluating the effectiveness of the system (Fry: 1980: 50-90).

Gambrill (1980: 90) stated that these requirements could be achieved through an effective referral system, provided there is regular feedback at all levels of the health care system. The feedback should always be clear, honest, informative and encouraging. Fry (1978: 103-110) observed that by the time the National Health System (NHS) was introduced in England the general principle of access to out patients by referral practices had been firmly established.

Experience has shown that no primary health care worker can possibly provide all the medical or social care, which his patients may require at any one time. Therefore, he must know where and how to get information and other facilities required by his patients. He must know what help the community can offer to people with social problems and above all, he must know how and when to refer patients to relevant levels of health care. Hodgkin (1978) stresses the importance of referral systems in primary health care, stating that early identification and diagnosis of diseases should be referred for specialist advice and/or hospital investigation. He also pointed out that early diagnosis and prevention of diseases is better than cure (Hodgkin: 1978: 26-581).

Fry (1980) pointed out that primary health care service could not function at optimum level unless the primary health care worker is supported by a satisfactory referral system. It was also observed that the general principles of access to out patient care in the 1970s has four distinct functions: First there is the traditional reason for referral such as referral for assistance for treatment and, referral to dispel the patient's anxiety. Secondly: there is referral so that arrangements can be made for hospital treatment. Thirdly: there is referral for illnesses where the hospital takes over continuing care because treatment usually lies outside the scope of the general practitioners. This applies particularly to certain serious and uncommon conditions such as various forms of malignant disease like Leukemia. Finally there is follow-up attendance from out-patients and from in-patient admissions, where patients are frequently attended to by junior and relatively inexperienced members of hospital staff (Fry: 1980: 90, 166-167).

There are other problems with referral systems such as non-urgent cases waiting for longer periods to see the specialist or undergo treatment. Continuity of care is often difficult and family care is not generally considered to be of great importance. However there are increasing public and government support for family practices, including the opening of many new university departments for the training of primary health care workers (Fry: 1980: 166).

It is clear that appropriate health technology is essential for the wide implementation of P.H.C. This was officially recognized and accepted in the declaration of the Alma-Ata at a joint World Health Organization and UNICEF conference on Primary Health Care (P.H.C.) in 1987. In this declaration it was also stated that health care is essential, and must come from the people themselves and not be provided for the people (Subcommittee P.H.C: 1993:71).

According to reports of workshops sponsored by the U.N. Children's Fund, it was observed that P.H.C. begins at home with the family, and as a result,

communities should be given the knowledge and skills to assume control over relevant P.H.C. technologies. Its success depends on well planned team work between communities, local health workers and supportive health care professionals who must act as teachers and/or supervisors in the referral process to health care centers and hospitals (U.N. Children's Fund: 1986).

International literature has also shown that most African countries rank the tertiary or central hospitals at the top of the referral pyramid. Usually, these central hospitals are associated with a medical school and offers medical and clinical services highly differentiated by functions, technical capacities and skills. These central hospitals tend to be located in cities and metropolitan areas. Though they are intended to provide primary health care at a tertiary level including referral services for a broader population, they actually serve a disproportionately urban clientele who are richer and can afford any cost incurred. Secondly, because most of these central hospitals are located in urban areas, they are usually not accessible to the rural population who are far-off and can't afford the costs involved (Shaw and Edward: 1993: 34-44).

Poorly trained health personnel and insufficient supplies of health facilities at the primary and secondary levels of health care units have always been a problem. Also there is the problem of uneven spreading of health resources over a particular region. This has resulted in poor medical services, leading to a lack of confidence amongst the community, in health care systems, especially the rural communities. Hospitals could provide a mixture of preventative and curative services responsive to up to 98% of local health care needs. Thus explaining why clientele often by-pass poorly functioning health care facilities and intermediate referrals to seek quality care at full-fledged hospitals (Shaw and Edward: 1993: 39).

Kohn *et al* (1976) observed that referral systems differ from one geographical area to another. As a result, the provision of health care facilities differs from

region to region. In some regions prevailing facilities make possible frequent referrals while in others referrals are less frequent (Kohn *et al:* 1976: 188).

According to Marcia *et al* (1992) it was found that referral and co-ordination are major and important parts of executing planning actions. Referrals direct clients for information, treatment, assistance, support or help with decision making. Referrals should be written and supplemented with documents. Verbal interactions will also help clarify the written referral. Two types of referrals have been identified. The open referral which may involve any official initiating a referral for discharged persons and the closed referral, which involves only the designated individuals to order or write such referrals (Marcia *et al:* 1992: 693-694).

Marcia *et al* (1992) also observed that the referral process should be well explained and discussed with staff members and clients before any decision concerning referral should be taken. Lastly copies recommending referral should be documented as well as documenting the outcome of the referral in the client records (Marcia *et al*: 1992: 693-694).

Fry (1978) observed that each country has developed its patterns of health care based on its own history, culture, political philosophies, economics and education, religion, geography and resources (Fry 1978: 103-110). Wood *et al* (1981) observed that the village health worker, the dispensary, the health care center and the district hospital form the various stages in what is called the referral system. A referral system should work in both directions, though in practice relatively few patients are referred successfully. This is mainly because of the great difficulties in transportation and the fact that many patients are too weak to travel or are frightened to leave their home areas. Sick people who need hospital care often by-pass the dispensaries or health centers. Wood *et al* (1981) also mentioned the importance of referring patients with a detailed description of

the patient as well as the treatment the patient has previously undergone (Wood *et al:* 1981: 94, 133).

It is observed that distance from the clinic is of particular importance to the poor people who are unable to afford the bus and other transport fares and who do not own cars, especially if they have large families. It was also noticed that if cases referred to the clinics are inadequate, or the services are poorly organized, there may be a delay in receiving treatment and its effectiveness may diminish (Sidney *et al:* 1981: 13).

According to Hart *et al* (1990), a major problem with patients is that of keeping up-to date information, and having sufficient knowledge of the enormous range of health and welfare services which exist in the community for them. Trying to find out about any available service can be time consuming unless there is some local scheme for obtaining reliable information quickly. More often than not these schemes are lacking in most third world countries, South Africa being no exception.

In a recent report by UNICEF, it was observed that the majority of births take place safely in homes and villages. Occasionally there is a need to refer women in labour to other health care units. In order for referral systems to work properly there must be good communication links between the community and the health care units in and around the community, Ongoing dialogue must also be encouraged by governments dedicated to the primary health care concept. Ideally, pregnant women should be identified for referral on a non-emergency basis, however some will inevitably require urgent action. All communities in which deliveries occur should develop a referral system in concert with the health system. Specific methods to shorten the critical time period between when a referral decision is made and when the higher level of medical care is provided should be well defined for each community. At the village level, this method will

be modified according to the availability of transport, road and weather conditions (U.N. Children's Fund: 1985: 40).

2.1.2: SOUTH AFRICAN LITERATURE

In South Africa, a major plan of effective Health Care System is to decentralize the management of the delivery of health services to provinces, districts and institutions in order to increase efficiency, local innovation, empowerment and accountability (ANC: 1994:59). Health services in South Africa have been so fragmented and inequitably distributed that it is essential to unify it into a single system. Decentralization without proper coordination, linkages and planning could result in a more fragmented inequitable health delivery system. However, it is useless to identify patients "at risk" unless plans for dealing with them exit. This often implies referral to a health facility at higher level (Hart *et al*: 1990:28).

In South Africa, it has been observed that the referral option is an important part of primary health care and should not be abused. To assume that hospitals and clinics are anxious to control their own patient intake and as a result will not accept patients from rural areas without a specific referral note is a misconception. Downward referral, feedback to the local health center and or lower levels of health care units, are of prime importance if health for all South Africans is to be achieved (Hart *et al:* 1990:28).

Secondly, Hart *et al* (1990) also observed that it is important for adequate instructions to be sent with each patient so that effective referrals can be achieved. These instructions can also be of an instructional manner that can help for future referral. They identified two types of referrals. Internal referrals are within health units and external referrals to other health units. They are both parts of good care for those with special health needs. The difficulties of transporting patients to other health facilities were observed as major barriers to referral and as a useful solution to these problems some proposals were made. One of these is the "flag system" where a flag is raised at the roadside obliging any passing

government vehicle to stop and transport the patient to the nearest health care center. However, in South Africa, it is not only government vehicles, which can be obliged to carry needy patients. Private transports in most cases do carry needy patients stranded by the roadside (Hart *et al:* 1990: 25-28).

The subcommittee on P.H.C. in South Africa described referrals as a reciprocal process between the health care units and levels, where each can ask for support from the other. This reciprocal process is one where the lower health care units refer cases to higher health care units like hospitals. These higher health care units, on the other hand, give feedback and refer problems and patients to successive higher levels in the health care system. Referrals also imply a two-way exchange of informing and returning patients to those who referred them. For example, from a lower health level to the community worker, furnished with appropriate information about the patient's condition and instructions for follow-up care. In addition, it implies providing guidance to community health workers on ways of dealing with problems referred to them.

Referrals services also provide secondary health care, which is relying on more specialised health care services, for example radiographic diagnosis, general surgery, care for women with complications in pregnancy or childbirth, and the diagnosis and treatment of common or severe diseases. Trained staff in such institutions at districts or regional hospitals provides this kind of care (Subcommittee, P.H.C: 1992:71).

P.H.C. is key to attaining the goal of health for all in the 21st century. This is in line with the Alma-Ata conference on P.H.C. where it was stated that, everyone in the community should have access to health care and everyone should be involved in promoting good health. Related sectors should, in addition to the health sector, work in collaboration to achieve these goals. At the very least, it should include the education of the community on health problems, prevalence

and occurrence of diseases and on methods of preventing and treating of these diseases (Subcommittee P.H.C: 1992:71).

Primary health care is not just a cheaper simpler approach to the delivery of health care, nor is it a simple basic health intervention. It is a concept, which is inter-active within itself, and if properly executed, will be the best possible form of health care for every South African rich and poor alike (ANC:1994: 21). For P.H.C. to be successful there must be an appropriate health technology. This means the association of methods, techniques and equipment, which together with the people, can contribute significantly to solving health problems. A major step towards this move will be linkages not only with academic or research institutions (highest health care levels) to co-ordinate the development of new technology and technological procedures, but also with the lower health care units (ANC:1994: 60).

The promotion of the concept of a continuance of health care should be an underlying principle. For health care to become meaningful, people who are referred from one part of the health care system to another must feel the logical aspect of their referral as well as accept the fact that they are still within one co-ordinated system. In fact, health care should include both primary and hospital care to ensure the continuance of health care from the primary, secondary and to the tertiary levels. This is to ensure the early identification and diagnosis of disease, the treatment of disease and a rehabilitation of those already affected (Sidney *et al*: 1981: 9-21, 25-32).

2.1.3: CONCLUSION

In the light of this survey of literature it is then possible to sumamrise the normative principles and ethical vales that should inform an effective referral system as follows:

- Accessibility
- Acceptability

- Affordability
- Availability
- Accountability, and
- Inclusiveness.

In the rest of my research report I will constantly refer back to these principles and values, and where necessary or possible, further analyze them. Before I proceed with my discussion of the study area and my methodology, it is expedient to first of all give an overview of the controversies and dilemmas surrounding the position of traditional healers in public health care. This will be a normative-ethical overview that will be followed up in chapters 5 and 6 with discussion of empirical data.

CHAPTER 3

THE ROLE OF TRADITIONAL HEALERS IN P.H.C.

3.0.1: INTRODUCTION

The aim of this chapter is to get to grips with the normative-ethical dimensions of the controversies and dilemmas surrounding the position of traditional healers in public health care. Addressing the issues of defining what a traditional healer is, as well as the tensions between traditional and western medicine, I then discuss the need for an integration of traditional healers in the public health system of South Africa.

3.1.1: DEFINITION OF TRADITIONAL HEALERS

Traditional healers have been defined by WHO as one who is recognized by the community in which he/she lives as competent to provide good health using vegetables, animals, minerals substances and 'other methods' based on social, cultural and religious background as well as the prevailing knowledge, attitudes and beliefs regarding physical mental and social well-being and the causation of diseases and disabilities in the community (Van Rensburg *et al:* 1992). Several types of indigenous health practitioners exist and there has been much confusion regarding the definition and functions of indigenous practitioners. The term such as 'witchdoctors' 'inyanga', 'mutiman', 'healer' and many others are used interchangeably to denote a wide variety of practitioners whose role involves the treatment of illness, and those who are believe to use supernatural powers to cause and/or cure illnesses. Another distinction with regards to indigenous practitioners is based on their different categories which, though overlapping in some instances, cannot be subsumed under one term. Only generic terms such as healers, or practitioners can be used. In all society South Africa included,

there are several categories and types of health specialist. For example, birth attendants, witchdoctors, psychosocial specialist, and physiotherapists, just to name a few (Nyamwaya 1995).

However not all traditional healers are viewed by community members in this light. Some members in the community see traditional healers as an apostle of the devil. According to Schroder (1986), traditional healing is the old African Tswana way of preventing, treating or healing illness, practiced by practitioners who learn these skills from traditional healers in some kind of training courses. It should however be noted that, the above definitions are not sufficient to define categories for all practiced medical systems in the world. For instance the old traditional Indian Ayurredic medicine is both scientific and traditional. Notwithstanding, for the existing health care system in South Africa these definitions are sufficient to distinguish traditional medicine from modern or scientific medicine.

3.1.2: TRADITIONAL VERSUS MODERN MEDICINE

Both the modern and the traditional healers have the same goal, namely to help the sick and the ill at ease. They either cure the illness or relieve pains and suffering and/or comfort the suffering and their relatives (Chavunduka: 1978). Gumede (1990), have differentiated traditional from modern medicine in South Africa (Also see Staugard: 1985).

- Modern healers are western in origin, have been imported into Africa and are called practitioners or doctors. Traditional healers are indigenous and African in origin, and the are called 'medicineman', traditional healers or herbalists.
- Modern healers are regarded as rational while traditional healers are looked upon as irrational.
- Modern healers are regarded as scientific, while traditional healers are regarded as empirical and unscientific.

- Surgical procedures by modern healers are planned, scientific and based on the study of gross and morbid anatomy. Their operations are done under deep anesthesia, and high technology is available to provide the back up system. Surgical procedures by traditional healers are seen as unscientific and regarded as crude and unplanned in the view of modern understanding of healing.
- Modern healers are trained for seven years after standard ten and training is open to any one who has the necessary means and required qualifications to enter medical school, while the training for traditional healers is passed down from father to son or from master (inyanga) to trainee. This type of training usually takes a lifetime, however the constitution of the Inyanga's national association (Article 7.1) prescribes a period of ten years.
- For modern healer's diagnosis entails determining the causes of an illness while for the traditional healers it is not only what illness ails the patients but also who caused the illness.
- The modern healer's approach is specific and individualistic, streamlined to meet the present problems that is, for an eye problem there is an eye specialist, for pregnancy problems there is a gynecologist etc. While the traditional healing approach is holistic. Traditional healers regard man as a holistic being including his body mind and soul, therefore healing is a total process involving the living and the dead, the natural, prenatural and the super-natural in addition to the patient, and finally,
- The modern healer treats the disease, destroys the offending organism in order to cure the patients, while the traditional healer treats the patient within his environment, physically, emotionally and spiritually.

It should be noted that there are many other differences between the modern healers (doctors) and the traditional healers. These however have been selected for the purpose of this study. These differences will be useful in further

discussion as to why traditional healers are not included, and should be included into the Primary Health Care (P.H.C.) System in South Africa.

3.1.3: NEED FOR INTERGRATION IN THE P.H.C. SYSTEM

There has been a long and burning need for the integration, and the World Health organisation (WHO), has been encouraging the use of traditional medicine especially in developing countries by promoting the incorporation of its useful elements into national health care systems (Akerele: 1987; Sindiga: 1995). The reasons advanced for the use of traditional medicine is the fact that modern medicine is failing to cope with current morbidity and mortality rates especially in less developed countries. High morbidity rates typical in Africa have been attributed to parasitic infectious diseases such as malaria, schistosomiasis, and trypanosomiasis. Respiratory infections like pneumonia, tuberculosis and water-borne diseases such as dysentery, typhoid and cholera have been observed to be endemic in many parts of Africa leading to the high mortality rates in the continent (Sindiga: 1995).

As a consequence, UNICEF and WHO since 1975 have been emphasizing a P.H.C. approach, which utilize local human and material support available in a community to provide the underserved population. This approach was adopted at the 1978 Alma-Ata International Conference on primary health care. At the conference, health was declare a universal human rights and a declaration was issued urging governments to provide accessibility, affordability and socially relevant health care to each individual (Sindiga: 1995; Akerele: 1987).

This approach that actually aimed at achieving 'health for all by 2000' calls specifically for greater utilization of traditional medicine. Against this background WHO have been encouraging the incorporation of useful elements of traditional medicine into national health care systems (Akerele: 1987). The history of the integration of traditional medicine with modern medicine dates back in 1977 when the World Health Assembly (WHA) drew attention to the potential of

traditional medicine, especially its human power reserve in national health care system. This urge was further highlighted in 1978 when the crucial role of medical herbs in the health care systems of many developing countries was highlighted. It is argued that if the majority of the rural population in developing countries have to be reached by some form of official health care, then efforts have to be made to use local resources, more especially as large number of the rural population do not always utilizes existing official health care services. One reason advanced for this lack of utilization is because most rural people are suspicious of (Western) modern medicine partly because it does not tolerate local beliefs and behaviors related to health matters (Sindiga: 1995).

This has led to the potential of traditional healers in most African countries to be recognized. It is estimated that over 75 percent of the rural population in Africa seek health care among traditional healers (Baquar: 1995; Sindiga: 1995). It has been observed that "From West Africa to Central Africa and Eastern to Southern Africa, traditional medicine is being evaluated with a view to instituting its participation in the national health care system" (Sindiga: 1995: 4).

Due to the doubts about the effectiveness of modern medicine (Staugard: 1985), and the poor and strained network of modern health facilities in developing countries pressure has been mounting especially with the emergence of the AIDS pandemic. As a result, traditional medicine is being advocated, although there are other reasons for this as well. First, it is an integral part of every culture developed over many years. Thus it is the effective way in curing certain cultural health problems. Second, it is socially acceptable and has the widest spatial coverage with each community having its own healers. Third its approach is holistic and views diseases and illness to be a disequilibrum of social groups with the total environment. Finally, it is efficacious and the fees charged by traditional healers are more often than not affordable (Sindiga: 1995; Baquar: 1995). It is furthermore observed that traditional healers not only cure the sick, but give reasons and causes of illness, act as mediator between the people, their

ancestors and the gods. They also alert the people on coming disaster, interpret them and offer alternatives and carry them out like sacrifices and offerings (Swiderski: 1995). Judging from the above, it is evident that the role of traditional healers in any society goes beyond providing good health.

There have been many debates about the place of traditional medicine in many African countries. In Kenya for example the government in its 1979 National Development Plan stated that: "Traditional medicine and health care are an important part of the life of the people in the rural areas. However more information is needed and will be collected during this plan period with regard to both its substantive aspect and its potential link with government institutions ... Furthermore, considerations will be given to the manpower aspects of the traditional sector, for instance the extent to which certain cadres of selected traditional sector practitioners such as midwives, might be encouraged to serve in government health institutions in rural areas" (Kenya: 1973: 136 Quoted in Nyamwaya:1995).

3.1.4: SCEPTICISM ABOUT TRADITIONAL HEALERS

There have been many doubts on the potentials, and concerning the integration of traditional medicine into our modern world health care system. Technically, it is argued that traditional medicine lacks the scientific research support essential to any line of specialization. Also, the lack of a comprehensive program of research into traditional medical concepts, therapeutic strategies and pharmacopoeia has always been a major point of concern. As a result of this lack of technical support to traditional medical practitioners, many harmful practices and toxic substances are widely being used, with the users and practitioners unaware of the dangers involved (Nyamwaya: 1995). These negative effects, including delayed referrals of cases requiring complicated surgical intervention which occurs from time to time due to claims by some traditional healers that they can treat all medical conditions, often gives the patients false sense of hope.

In today's South Africa, traditional healing has been elevated to a high income earning profession attracting both sexes and almost all age groups. This income-earning factor of traditional healers today has resulted in a high proliferation of poorly trained traditional practitioners who are not controlled by either the traditional social system or the modern government administration. Nyamwaya (1995) has observed that clandestine services can be easily abused especially as there is no system of sanctions affecting the activities. This research serves partly as a proposal for the recognition of support to traditional healing in South Africa, establishing a system of integration and regulation for it.

The practices of traditional healers are viewed by many in South Africa as unscientific, crude and uncivilized. In this light, a wide majority of the South African population is shying away from traditional healers and their activities. They are even regarded as encroachers in the medical field. It was remarked by one Dr. Kohler that, "I gather from all I have seen and heard today that there are a good many poachers in our medical hunting grounds" (Schimlek: 1950. Quoted in Gumede: 1990: 155). Although it is with caution that the role of traditional healers in South Africa's health care has been established (Gumede: 1990), this system of health care is still the least understood of all medical systems in South Africa.

3.2.1: TRADITIONAL MEDICINE AN INTEGRAL PART OF HEALTH CARE SYSTEM IN SOUTH AFRICA

Because of the serious doubts that have recently been raised about the effectiveness of modern medicine in its predominantly curative form as an instrument for the attainment of the goal of 'health for all', it might be relevant at this point to examine in some depth the question of whether we ought to reevaluate traditional medicine as an integral part of the health care system in South Africa. Considering the fact that traditional medicine is widely used in South Africa, more especially due to its effectiveness, and the fact that population pressure and indiscriminate environmental destruction threaten

medical herbs, there is great need for integration. Furthermore, traditional medicine needs to be protected, enhanced and developed, with specific legislation recognizing traditional medicine, with research institutions to undertake chemical analysis of traditional drugs (Sindiga: 1995).

It has been observed that in most communities illness can be divided in two categories, making a clear distinction between illnesses which can be treated by modern medicine and those which can only be treated by traditional medicine. Studies however in most rural communities indicate that this dichotomy is mainly cognitive and at behavioral levels any dichotomization is rarely maintained (Nyamwaya: 1995).

All indications show that, patients use both forms of health care (traditional and modern medicine) alternatively and simultaneously, in what Nyamwaya (1995) terms as 'sequential zig-zag'. There is a great deal of integration between the two types of health care systems. A second type of integration between traditional and modern medicine is a supplementary relationship especially in cases where only one of the two form of medicine can be used for the treatment and or prevention of an illness. This supplementary relationship comes into play when the intervention within one form of medicine is regarded as one that is extra within the framework of the other. Another form of integration may be described as one of competition. For example, in cases of acute sickness which are believed to be only biological in nature, the patient may decide to pursue either form of therapy. For example, indigestion can be treated with liver-salt bought over the counter or with an indigenous herbal mixture. If the condition persists the patient can consult either a doctor or a traditional healer. Finally, interaction between the two types of medical care can be seen as complementary. In this case, people view both types of health care as necessary for complete healing to occur (Nyamwaya: 1995). The above discussion is indicative that traditional medicine is used not only widely but also in very close conjunction with modern

medicine. This position calls for a proper understanding of traditional therapies and practitioners to facilitate consumer's satisfaction.

3.2.2: CONCLUSION

In the light of these considerations then, it seems as if we cannot escape the normative challenge of integrating traditional healers into the public health care system of South Africa. In the next three chapters I will show that this conclusion is also supported by empirical data.

CHAPTER 4

STUDY AREA AND METHODOLOGY

4.0.1: INTRODUCTION

This evaluation of referral system was undertaken during mid August to mid October 1999 using areas within the health regions of West Rand in Gauteng province (figure 1). Hospitals, community centres/clinics, traditional healers and other health services were visited and interviewed. This section focuses on the geographical overview of the study area, stating the reasons why the study area was selected for the research. It also discusses the techniques used in collecting the data, the problems faced during this stage of the research and how these problems were solved.

4.1.1: STUDY AREA

The West Rand area is one of four regions of the Gauteng province (figure 2). Gauteng is largely situated on the highveld region with an area of 18800 square kilometers, 1,5% of the country's total surface area. It has hot summers and mild winters with spells of very cold weather and frost in the south. It is situated 55 kilometers away from the Western side of central Johannesburg. The study area consists of 8 magisterial districts (figure 3), composed of 4 urban and 4 rural districts. Data of the community's profile of its provincial health department presents the size of the study area as follows:

DISTRICTS	SIZE IN HECTARES
Krugersdrop	28307,2334 hectares
Randfontein	147,6 hectares
Westonoria	147,000 hectares
Carltonville	331,392 hectares

Table 1

The study area was selected for the research work for the following reasons: First, its close proximity to central Johannesburg, second, its lack of proper health care facilities, and third, its poor communication networks. Fourth, the recorded high death rates in the region with high infant mortality further precipitated the choice of this region for the research.

4.1.2: CLIMATE OF STUDY AREA

The region falls in an area of hot temperatures in summer and cool winters. Average annual temperature ranges from 20 degrees centigrade to 25 degree centigrade, but in winter, average winter temperature may fall to between zero degree centigrade to 1 degree centigrade. Rainfall in summer is very moderate with afternoon thunderstorms and strong winds. The annual rainfall is 769 mm, mainly in the form of intermittent stormy downpours during the summer.

4.1.3: POPULATION OF STUDY AREA

The population of the study area is roughly about one million people. The people are distributed in the 4 districts in the study area as follows:

POPULATION	DISTRICTS
Krugersdrop	373,200
Randfontein	190,400
Westonoria	192,000
Carltonville	232,684

Table 2

With the highly concentrated population in the study area, there is the need to provide good and essential health care to the people of the region. High population concentration might for instance, lead to high levels of pollution in the area, which may affect the health of the people living in the area.

4.1.4: TRANSPORTATION

In the West Rand region particularly in the black areas, taxis are the main means of transportation. In white areas people use their own private transport. Buss services have since been stopped because of the 1997 violence in all four regions. Trains run from Randfontein to Kruersdrop to Johannesburg to the East Rand. Road transport is poor in informal settlement areas due to the poor quality of the roads. Most referral hospitals are not within walking distance and people cannot afford to pay the transport charges. For example, from Mohlakeng location to Leratong Hospital one must spend R 8,00 on a single trip. The Municipal clinic also does not have adequate ambulance services to transport patients to hospitals in cases of emergency. In the psychiatric service cars are used to transport patients.

4.1.5: HOUSING

Housing in affluent areas is formal with 100% electricity and clean tap water. Most of the informal settlements in the region don't enjoy equal facilities as the formal settlements. In some areas people squatted on unserviced land with no roads, electricity nor clean water. All these combined with high levels of unemployment leading to many health problems put enormous pressure on health workers as well as health services.

4.2: RESEARCH METHODOLOGY

Various research techniques were implemented in the collection of the research data. First informal interviews were conducted followed by formal meetings in the study area. Second, formal interviews using well-structured questionnaires were administered. I also used the participant observation method in the collection of the data.

4.2.1: INFORMAL INTERVIEWS

Many people were interviewed randomly in the study area. These people include clinic workers, shop owners, taxi drivers, traditional healers and medical personnel. This technique helped in exposing the feelings of the ordinary people who are generally underprivileged black South Africans. Notwithstanding, the respondents were not keen and were unwilling to talk, either because they were afraid, or reckless about the health situation of the community. To solve this problem, respondents were motivated with items such as free condoms to talk. This technique was very useful in helping me obtain some relevant information about my study area as well as the aims and objectives of the study.

4.2.2: FORMAL INTERVIEWS

Formal interviews were conducted in the study area with the help of two other personnel working in the area. Their choice was of great relevance because they were able to identify all other health institutions, including traditional healers in the study area. For most cases during the formal meetings, questionnaires were administered to health workers which allowed them express their opinion, values and perception of the effectiveness of the referral systems in the study area in particular, and South Africa as a whole.

These techniques were not without problems as in most cases it was almost impossible to meet or organize meetings with medical doctors, since most of them were often very busy. Secondly, some of the doctors in the study area are non-South African citizens. As a result, they lack the knowledge of the real situation of the common South African in the rural areas of the study area. Those formally interviewed also included traditional healers. A formal meeting of traditional healers were organized which became very useful since it was possible to interpret the questions asked in the questionnaires to the traditional healers who were mostly uneducated.

4.2.3: THE USE OF QUESTIONNAIRES

Well-structured questionnaires (see Appendix 1) were administered and this technique accounts for the major source of data collection. A major problem faced at this stage of data collection was that most of the respondent could not understand nor speak English. Most of the respondent can only speak Afrikaans or Zulu. However with the assistance of the two health workers most of the questionnaires were interpreted with few difficulties to the respondents. The use of interpreters for each and every questionnaires administered was time consuming and difficult especially for the traditional healers.

4.2.4: PARTICIPANT OBSERVATION TECHNIQUE

For most cases I was not only holding formal meetings or administering questionnaires, but I was actually participating in the activities of the people themselves. Some of these activities include health forums, general meetings, as well as paying unofficial visits to health officials, especially traditional healers. As an observer, and a listener I was able to acquire information about the study area, which I would not have acquired during the questionnaire stage of my research. This method was also useful because I was able to get first hand information which most respondents were unwilling to give especially during informal meetings. Though the people from its inception were suspicious of my activities, my two interpreters and assistant helped me to clarify my aims and objectives to the community members.

GAUTENG IN NATIONAL CONTEXT

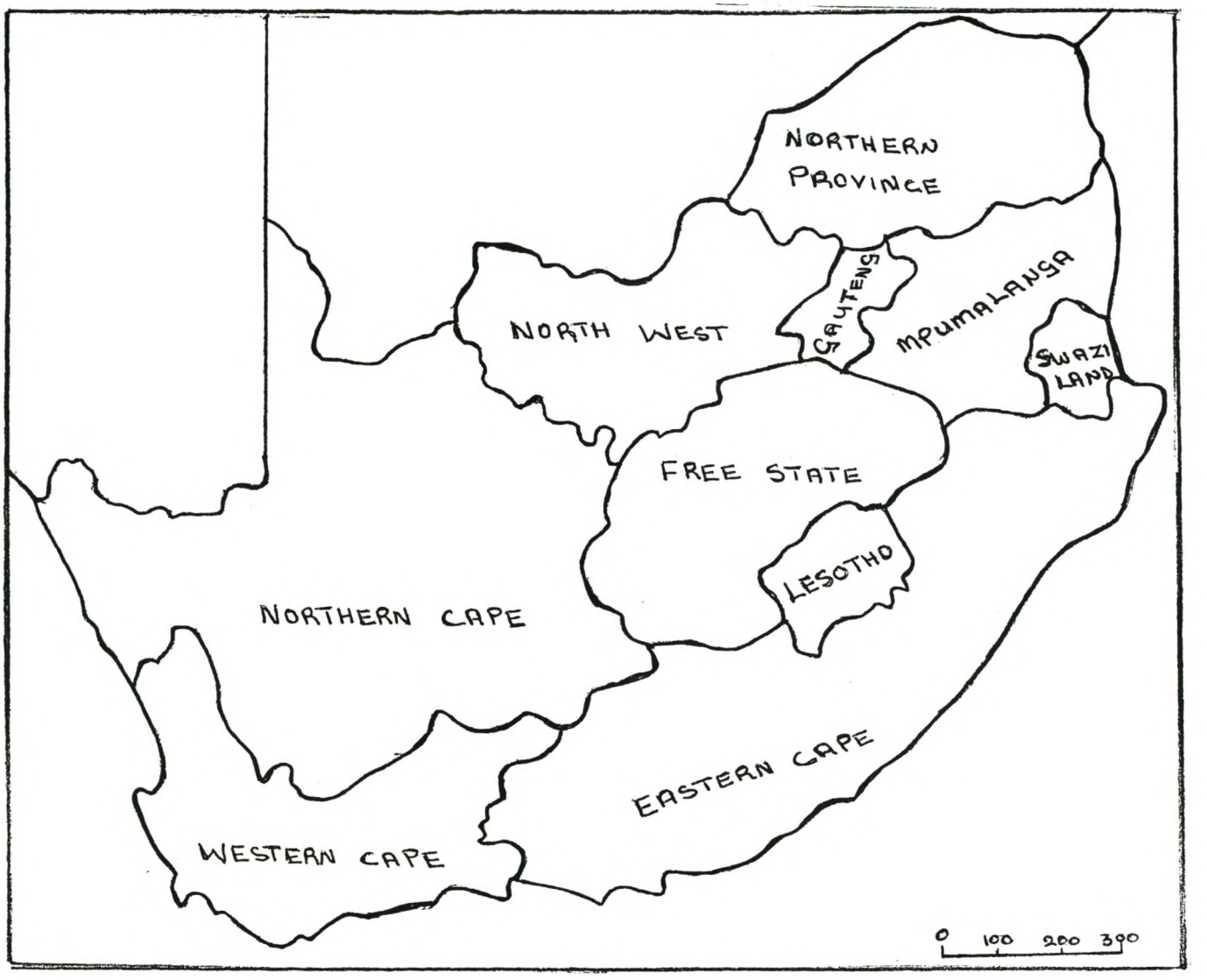

Figure 1.

GAUTENG PROVINCE

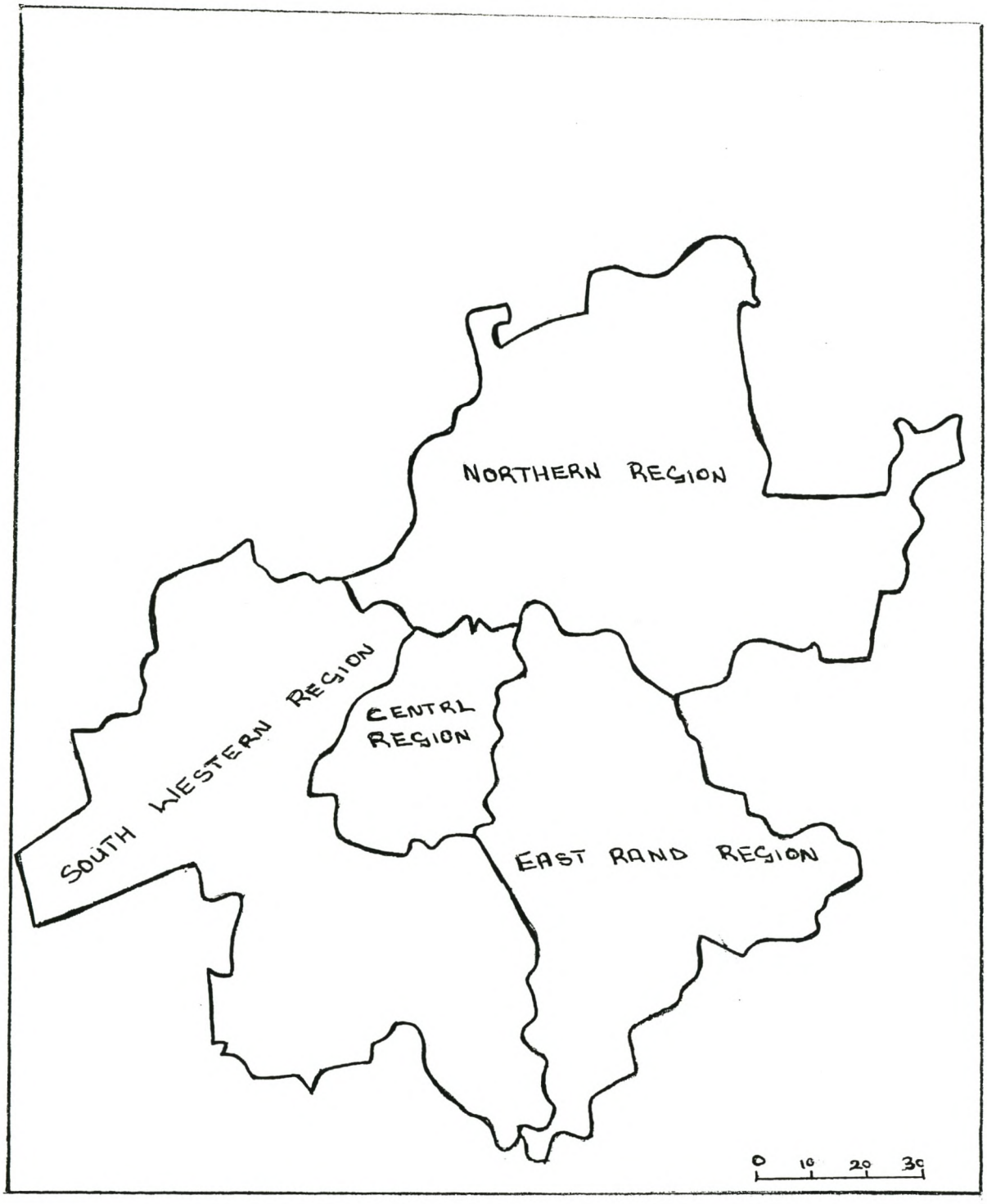

Figure 2.

STUDY AREA: THE WEST RAND REGION

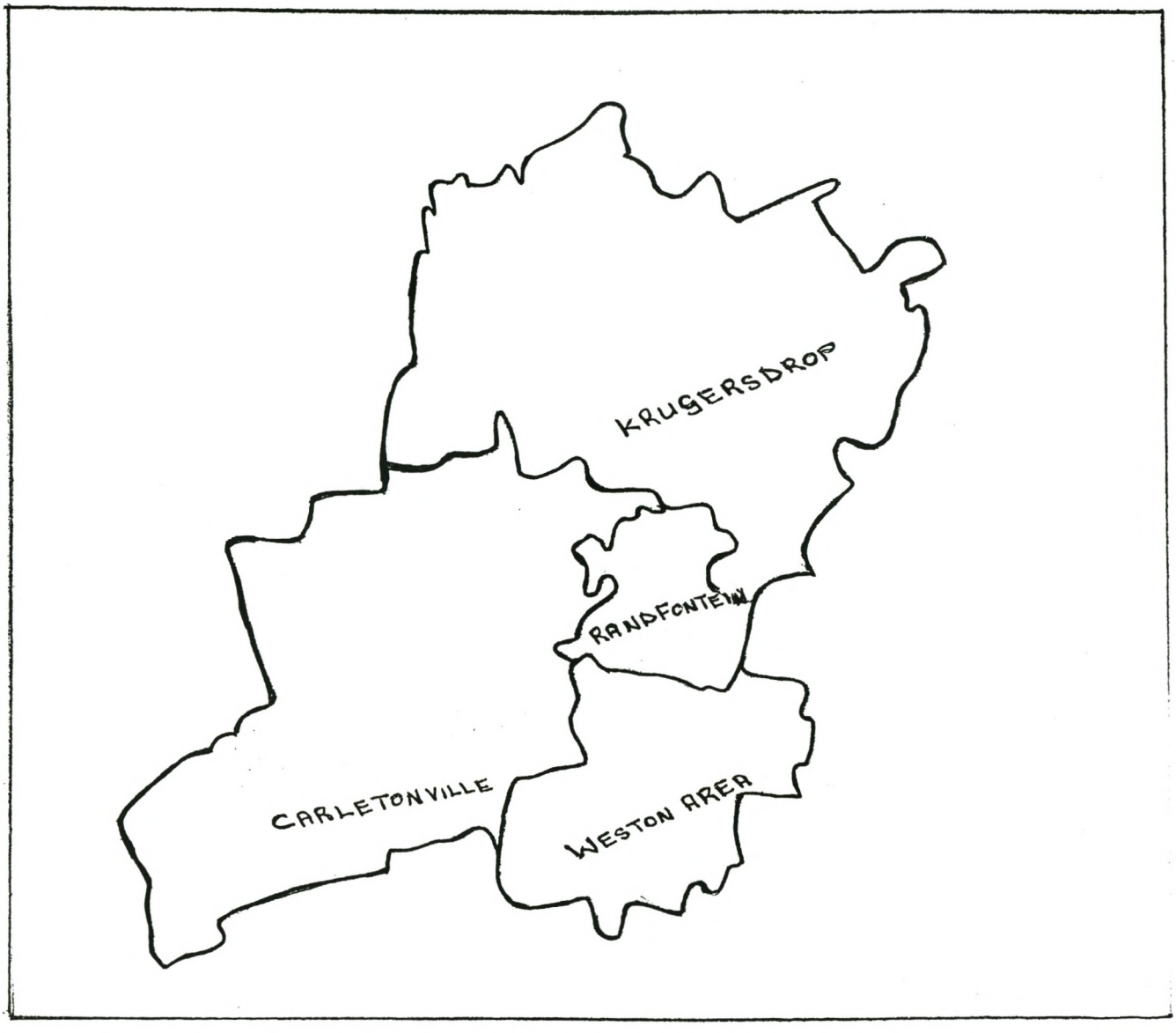

Figure 3.

CHAPTER 5

DATA PRESENTATION AND ANALYSIS

5.0.1: INTRODUCTION

This chapter deals with the presentation and analysis of the data. The section is divided into four subsections. Section 4.1 deals with traditional healers. 4.2 presents and analyses health NGOs. 4.3 deals with the clinic/community centres and the last section, 4.4, will present the data and analyses of the hospitals. The analysis in this chapter is purely descriptive and makes use of simple statistical methods, such as simple percentages and averages. This method will help in drawing conclusions in the discussion part of this work.

5.I.1: TRADITIONAL HEALERS

A total of 36 traditional healers were identified and interviewed through the use of questionnaires, formal and informal interviews. Table 1(a) below represents the sex composition of the traditional healers interviewed.

5.1.2: SEX COMPOSITION OF TRADITIONAL HEALERS

RESPONDENT	NUMBER	%
MALE	9	25
FEMALE	27	75
TOTAL	36	100

Table 1(a)

Of 36 traditional healers that were interviewed 9 were males accounting for 25 % and 27 were females accounting for 75% of the total interviewed. The sex

composition of the traditional healers is important for the study because I was able to identify if certain practices of the traditional healers were gender motivated.

5.1.3: AGE COMPOSITION OF TRADITIONAL HEALERS.

Of the Traditional healers interviewed, their ages ranged from 26 years old to 61 years. Table 1(b) below presents the age composition of the traditional healers interviewed in the study area.

Age composition of traditional healers

Respondent Age	Number	%
26-30	4	11.1
31-35	6	16.7
36-40	8	22.2
41-45	3	8.7
46-50	9	25
51-55	2	5.6
56-60	1	2.8
61+	3	8.3
Total	36	100

Table 1(b)

Of the traditional healers interviewed most of them were between the ages of 46 -50 years old accounting for 25% of the total interviewed. Very few, only 4 of the 36 traditional healers interviewed were between the ages of 26 - 30 years old accounting for only 11.1% and only 3 of these traditional healers were older than 60 years accounting for 8.3%.

5.1.4: EDUCATIONAL STATUS OF TRADITIONAL HEALERS

Educational status of traditional healers

Educational Status	Number	%
Never been to school	7	19.4
Primary	27	75
Secondary	2	5.6
Total	36	100

Table 1(c)

It was discovered that 27 of the 36 traditional healers interviewed in the study area have primary level education accounting for 75%. Only 2, accounting for 5,6% of the traditional healers, have attended secondary education. 19.4% of the 36 traditional healers have never been to school. One can therefore conclude that 99,4% of the traditional healers of the study area have no education at secondary school level.

5.1.5: RELIGIOUS AFFILIATION OF TRADITIONAL HEALERS

Table 1(d) below presents the religious affiliation of the traditional healers interviewed. It was discovered that up to 86,1% of the 36 traditional healers interviewed are Christians, while 13,9% of them are pagans. One can say that despite the traditional healers' practices most of them (86,1%) still confess belief in God and one can therefore expect that they put God first in their treatments.

Religious affiliation of traditional healers

Respondent affiliation	Number	%
Christian	31	86.1
Pagan	5	13.9
Total	36	100

Table 1(d)

5.1.6: TREATMENT OF CASES BY TRADITIONAL HEALERS

It was discovered that the traditional healers of the study area treat both endogenous and exogenous diseases. Endogenous diseases originate from within the body or as a result of internal causes. They are caused by structural or functional failure of the body's organs or system, e.g. high blood pressure/hypertension. While exogenous diseases originate from outside the body or an organ of the body due to external causes such as bacterial or viral agents foreign to the body.

It should be noted at this point that some diseases could be both endogenous as well as exogenous. Examples of such are sexually transmitted diseases, diabetes, and cancer, to name a few.

Frequency of cases received by traditional healers

No of visits	Number	%
Daily	26	72,2
One per week	4	11,1
2-3 per week	6	16,7
Total	36	100

Table 1(e)

26 of the 36 traditional healers of the study area, amounting to 72,2% of the total, received patients daily and 58,2% of these cases were unable to be treated by the traditional healers (see Table 1(f)). Only 41.7% (see Table 1(f)) of the cases could be treated by the traditional healers.

Cases unable to be treated by traditional healers

Response	Number	%
Yes	21	58,3
No	15	41,7
Total	36	100

Table 1(f)

Of the 58,3% of the cases that traditional healers were not able to treat, only 9,5% of them were referred to other health institutions as a form of solution to the problem. It was discovered that only 30.6% of the traditional healers of the study area do refer patients regularly to other health institutions. The remaining 69,4% don't refer cases to other health institutions and justify their reasons as listed below.

- Because of lack of reciprocity between different health institutions.
- They lack information about other health institutions.
- They are being looked down upon by other health institutions.
- Lack of co-operation between the different health institutions.

Due to the fact that the traditional healers are being under-valued by other health institutions only 2 of the traditional healers, amounting to 5,6% of the total, healers received cases from other health institutions mostly from other traditional healers and clinics. It was also discovered that of the 5,6% of the traditional healers, who receive cases from other health institutions, 100% of them do treat the case successfully. It was also observed that 100% of the 5,6% of the traditional healers who receive referred cases from other institutes do give feedback to these institutions by talking to the referring institutions.

5.1.7: RELATIONSHIP WITH OTHER HEALTH INSTITUTIONS

Table 1(g) below represents the relationship between the traditional healers and other health institutions.

Relationships with other health institutions

Relationship	Number	%
Working relationship	13	36,1
Poor relationship	12	33,1
No relationship	11	30,6
Total	36	100

Table 1(g)

From table 1(g) above 36,1% of the traditional healers have a good working relationship. 33% and 30,6% have a poor relationship and no relationship respectively with other health institutions. A total of 63,7% of the traditional healers have poor or no relationship with other health institutions. It was observed that some of the problems faced by the traditional healers were;

- The traditional healers were generally misunderstood by other health institutions.
- They are treated in a biased manner and often labeled as witch doctors.
- They lack opportunities and are not recognized as health workers.
- There is a lack of communication between the different health institutions and health institutions don't work hand in glove with the traditional healers.
- They lack their own clinics to do their work and they are usually unemployed.
- Finally it was observed that the traditional healers are not trained by other higher health institutions.

However, it was observed that traditional healers in the study area are trying to have meetings with government officials as well as forming an association to cater for their numerous problems. It was observed that despite the poor relationship between traditional healers and other health institutions, these health institutions are quite useful to the traditional healers. Some of the usefulness ranges from the fact that they are trained in Primary Health Care especially for the treatment of TB and other basic health care methods. Only 16 of the total of

36 (44,4%) of the traditional healers interviewed says other health institutions are not useful to them in any way. And up to 55,6% of the total number of traditional healers say other health institutions are useful to them due to the reasons already mentioned above.

5.2.0: HEALTH NGOs (Non Government Organisations)

A total of 4 Non Government Organisations (NGOs) that deal with health matters were identified in the study area. These Non Governmental Organisations (NGOs) were The National Institute for Crime and Rehabilitation for Offenders (NICRO), South African National Council for Alcoholic (SANC), Cancer Association (CA) and Family Life Centre (FLC).

The positions of the respondents interviewed in these health NGOs ranges from social workers, administrators and managers. Their ages ranging from 23, 28, 29 and 30 years old respectively. From the research it was evident that all of the workers interviewed under the health NGOs fall under the lower middle age group.

5.2.1: SEX COMPOSITION OF WORKERS

The table (2a) below presents the sex composition of the workers interviewed in the health NGOs of the study area.

Sex composition of workers

Sex	Number	%
Male	1	25
Females	3	75
Total	4	100

Table 2 (a)

A total of 75% of the health NGO workers interviewed were females and only 25% of the workers interviewed were males. In the study area most of the health NGOs workers, are mostly females (Table 2(a)).

5.2.2: RELIGIOUS AFFILIATION OF HEALTH NGO WORKERS

3 of the total number of health NGO workers interviewed in the study area amounting to 75% were Christians while only 1 amounting to 25% of the workers were non-Christians (see Table 2(b) below).

Religious affiliation

Religion	Number	%
Christian	3	75
Non-Christian	1	25
Total	4	100

Table 2(b)

It was observed that 100% of the health NGOs' workers interviewed in the study area are graduates. It was also noticed that a total of 6 different types of cases were received by the different health NGOs. The cases received by the health NGOs were cancer patients, women and child abuse, drug abuse, mental illness and assault and crime. Table 2(c) below represents the distribution of the cases received by the respective health NGOs.

Distribution of cases to health NGOs.

NGO	Cancer	Child abuse	Women abuse	Drug abuse	Mental illness	Assault /crime	Total/ per week
NICRO	_	15	27	_	_	8	50
SANCA	_	_	_	17	_	_	17
Cancer Association	17	_	_	_	_	_	17
Family Life Centre	_	_	_	16	_	_	16
Total	17	15	27	33	_	8	100

Table2(c)

It was observed that patients were received weekly by these health NGOs, and that 75% of these NGOs do treat their patients while only 25% are unable to treat some of their patients. However for the 25% who are unable to treat some of their patients, counseling, education and other support services are provided.

All of this health NGOs have had cases, which they cannot treat and in such a situation these cases were referred to other health institutions such as clinics. It was also noticed that institutions such as hospitals, clinics, children's homes, schools, NGOs and companies do refer cases to this health NGOs. It was also noticed that these referred cases were successfully treated through counseling and other social and economic support services. 100% of the health NGOs do give feedback to the referring health illustrations. Only 25% of the health NGOs do not refer cases to traditional healers. Up to 75% of the health NGOs do refer cases to traditional healers. In most cases as observed and according to informal interviews with the health NGO officials, cases referred by the health NGOs to traditional healers are those believed to be caused by witchcraft.

It was found that 75% of the health NGOs don't get feedback from the traditional healers. The reasons why the traditional healers do not give feedback to the health NGOs have been discussed in section 4.1.6 above. Finally it was

discovered that the health NGOs do receive cases that repeat themselves due to a lack of co-operation between the health institutions. As a result of this lack of good referral system amongst the health levels of the study area, cases keep on repeating themselves from one health institution to another.

5.3.0: CLINICS AND COMMUNITY CENTRES

A total of 22 clinics/community centres were identified in the study area. Those interviewed ranged from tutor, professional nurses and senior professional nurses. It was realised that all the respondents interviewed were females.

5.3.1: AGE GROUP OF WORKERS

Table 3(a) below presents the age groups of the workers interviewed in the study area.

Age group of workers

Age group	Number	%
26-30	2	9,1
31-35	3	13,6
36-40	9	41
41-45	3	13,6
46-50	4	18,2
51-55	1	4,5
Total	22	100

Table 3(a)

A total of 9 out of 22 clinic workers were interviewed. 41% of the workers are between the age group of 36-40 years old. Only 2 accounting for 9,1% of the total of 22 workers interviewed in the study area fall in the age group 26-30 years. Also very few workers, just 1 out of the 22 workers interviewed, (accounting for 4,5%), are between the age group of 51-55 years old. It was also observed that all the respondents in the study area were Christians attending

churches like Roman Catholic, Methodist, Lutheran Church, Zion Church and Apostolic Faith Mission Church.

5.3.2: EDUCATIONAL STATUS OF WORKERS

Table 3(b) below represents the educational status of the clinic workers interviewed in the study area.

Educational status of workers.

Educational status	Number	%
Standard 10	10	45,5
General Nursing (Diploma)	9	40,9
B.degree in Nursing	3	13,6
Total	22	100

Table 3(b)

Up to 10 out of the 22 workers interviewed (accounting to 45,5%) have secondary education. 9 of the workers, accounting to 40,9%, were general nurses and only 3, accounting to 13,6% of the workers interviewed had a Bachelors degree in nursing. Most of the workers in the clinics/community centres in the study area have education less than the tertiary level.

5.3.3: FREQUENCY OF CASES RECEIVED BY CLINICS

All of the clinics received patients 24 hours a day. However 86.4% of the clinics only work five days per week. Only 4,5% of the clinics and 9.1% of the clinics work 6 and 7 days a week respectively (see Table 3(c) below).

Frequency of cases received by clinic and community centre

Time/ Day	Number	%
24 hrs	22	100
Monday to Friday	19	86,4
Monday to Saturday	1	4,5
7 days a week	2	9,1
Total	44	100

Table 3(c)

It was observed from the findings that these clinics and community centres receive both exogenous and endogenous cases. It was found that 81,8% of the total number of clinics/community centres do treat their patients (see Table 3(d) below), and only 18,2% of the total number of clinics sometimes cannot treat their patients.

Full treatment of cases by the clinics

Clinics	Number	%
Yes	18	81,8
No	4	18,2
Total	22	100

Table 3(d)

Of the 18,2% of the clinic, who sometimes could not treat their patients, only 25% of them usually refer these patients to other health institutions. The remaining 75% of the clinics simply give advice only to the patients. However it was noticed that all the 22 clinics interviewed referred cases to other institutions, and 100% of the clinics do receive cases from other institutions.

Table 3(e) below represents data of institutions that refer patients to clinics and community centres.

Institutions that refer patients to clinics

Name of institution	Number	%
Hospitals	2	9,1
Hospitals and Clinics	5	22,7
Clinics	6	27,3
Hospital, Clinics and Traditional healers	8	36,4
Traditional healers	0	0
Others	1	4,5
Total	22	100,0

Table 3(e)

From Table 3(e) above, clinics do not receive patients from traditional healers alone. 8 clinics accounting to 36,4% receive patients from hospitals, clinics and traditional healers. Only 6 of the clinics interviewed, accounting for 27.3%, do refer patients to other clinics and only 9.1% of the clinics do receive patients from hospitals. One can say therefore that there is a lack of co-operation between the health institutions of the study area, thus affecting an effective referral system amongst the health institutions. It was found out that 95.5% of the referred cases were treated by the clinics, and only 4.5% of the referred cases could not be treated by these clinics. The higher percentage of successful treatment of referred cases to the clinic stresses the importance of a referral system in primary health care.

It was also observed that all the clinics (100%) give feedback to the institutions that referred cases to them. However, clinics in the study area don't refer cases to the traditional healers and considered them not qualified as health officers. It was noticed that all clinics in the study area usually have reoccurring cases, that is cases reporting again after they have been treated already. If there was an effective referral system in the study area, then cases will not be repeated in the different health institutions. Thus solving the problem of patients moving from one

health institution to another only to find out that their illness could not be treated by a particular health institution.

5.3.4: REFERRAL BY CLINICS TO HEALTH NGOs

Table 3(f) below represents referrals by clinics to health NGOs. 19 of the 22 Clinics in the study area refer cases to the health NGOs accounting for 86,4% and 3 of the 22 clinics accounting for 13,6% do not refer cases to health NGOs.

Referral by clinic to health NGO's

Referral/clinic to health NGO	Number	%
Yes	19	86,4
No	3	13,6
Total	22	100

Table 3(f)

The following reasons were given by the clinics for not referring patients to the health NGO.

- There is no available data about the health NGOs.
- They also lack information about the health NGOs.
- Poor communication amongst health institutions.
- Lack of co-operation amongst these health institutions.

This further strengthens the fact that there is no effective referral system in the study area.

However, some clinics in the study area do get feedback from health NGOs and it is presented in Table 3(g) below.

Feedback to clinic from health NGOs

Response from NGOs	Number	%
Yes	16	72,7
No	2	9,1
Can't remember	4	18,2
Total	22	100

Table 3(g)

72,7 % of the clinics who refer cases to the health NGOs do receive feedback from the health NGOs while only 9,1% do not. It was also observed that 18,2% of the clinics couldn't remember if they received feedback or not. This, however, indicates a lack of proper records kept by these health NGOs and clinics.

5.4.0: HOSPITALS

A total of two hospitals were identified in the study area, the Leratong Hospital and Carltonville Hospital. The matron and the medical officer of the hospital respectively were interviewed and formally questioned. The matron was 58 years old and the medical officer 36 years old. For these two hospitals only these two health workers were chosen because they know and keep the records of the hospitals. For most cases the administration of the hospitals are usually controlled by either the medical doctor or the matron of the hospital.

5.4.1: SEX DISTRIBUTION

Table 4(a) below presents the sex distribution of the health workers interviewed in the study area.

Sex distribution

Sex	Number	%
Male	1	50
Female	1	50
Total	2	100

Table 4(a)

All of the people (100%) interviewed in the study area under this section were Christians.

5.4.2: EDUCATIONAL STATUS

All of the officials interviewed in the study area have received tertiary education. Table 4(b) below represents the data for the educational levels of interviewees

Educational status

Education level	Number	%
General Nurse (Diploma)	1	50
Medical Doctor	1	50
Total	2	100

Table 4(b)

It was observed that the hospitals in the study area receive both endogenous and exogenous cases. These hospitals operate on a 24-hours basis. According to the interviews conducted, it was observed that 100% of the hospitals do treat all their patients even-though it was observed that some of the hospitals have had patients whom they cannot treat. It was also observed that referred cases to these hospitals are mostly from other hospitals and clinics, and 100% of these referred cases were usually treated. Thus stressing the importance of referrals amongst health institutions.

Though it was realised that these hospitals do give feedback of the refer cases to lower levels of health institution, the matron of Leratong Hospital, says it is not the norm of the hospital. While the Medical officer of Carltonville Hospital claims a lack of knowledge of other health institutions, especially the traditional healers, as the main reasons why they do not refer to lower levels. The reasons for not referring cases to NGOs were as follows

- There are no qualified health NGOs in the study area.
- It is difficult to identify these health NGOs.

Generally, 100% of the hospitals give feedback to lower health institutions though with the exception of traditional healers. In most instances these lower health institutions are clinics.

This brings me then to the end of my data presentation and analysis. The next chapter will be devoted to the discussion of the results.

CHAPTER 6

DISCUSSION OF RESULTS

6.0.1: INTRODUCTION

The objectives of this chapter are to identify, discuss and interpret the relationships between various levels of health institutions in the study area. The chapter will also discuss results from Chapter 4 and the identified problems affecting an effective referral system in the study area.

6.1.1: LEVELS OF HEALTH CARE

In the study area four levels of health care units were identified. These health care levels include traditional healers, health NGOs, clinics and hospitals.

6.1.2: TRADITIONAL HEALERS

It was observed that health care levels are in a hierarchical and an ascending order. The traditional healers were observed to be at the lowest level of health care in the study area. Though this health care level is regarded as the lowest level, they received 72,2% of their total patients daily (Table 1(e) above). It was also observed that most of these traditional healers are able to treat the cases they received (Table 1(f) above). From the above stated statistics therefore, it should be noted that levels of health care institutions should not be overlooked, as each of these health care institutions are important in their own right.

6.1.3: HEALTH NGOs (NON GOVERNMENT ORGANISATIONS)

Studies from this research revealed that there are no more than four health NGOs in the study area. The health NGOs are second from below in the health care levels as identified in the study area. The research revealed that most of the workers at this level in the study area are women (Table 2(a)). However at this

level of P.H.C. 50% of the cases received are of children and women abuse, and crime-related matters. Only the Cancer Association treats cancer-related cases. Notwithstanding, the treatment provided at NGOs are mostly counseling of the patients involved (see Table 2(c) in chapter 4).

6.1.4: CLINICS AND COMMUNITY CENTRES

Clinics and community centres were observed to be at the third level of P.H.C. in the study area. It was observed that most of the workers at this level of health care are between the ages of 31 to 35 years old (Table 3(a)). Though 45.5% of the workers were standard 10 holders, up to 40,9% and 13,6% were general nurses and holders of a Bachelor's degree in nursing respectively. However, no doubt changes the fact that most of the 10 workers at this level of P.H.C. require more training if Primary Health Care is to be effective and equitably distributed to all South Africans. These clinics receive patients 24 hours a day and treat 81,8% of the patients they received (Tables 3(b) and 3(c) respectively).

6.1.5: HOSPITALS

Hospitals are the highest level of primary health care in the study area. A total of 2 hospitals were identified in the study area. Most of the patients visiting the hospitals, though, claimed that the hospitals are generally expensive. Sources from the informal interviews held with hospital workers claimed that the hospitals are expensive because of the following problems they faced: First there is the problem of a shortages of infrastructure such as ambulances, computers and other hospital equipment. Secondly, a lack of, and poor state of the hospital infrastructure often force hospital administrations to charge high prices for their services.

6.2.0:RELATIONSHIPS BETWEEN HEALTH CARE LEVELS

The research revealed that there are many types of relationships, namely poor working relationship or no relationships between the health care levels of the

study area. In the study area, this relationship is not reciprocal with traditional healers and other health care institutions (Table 1(g)). Clinics in the study area generally have a reciprocal relationship between clinics and the two hospitals in the study area (Table 3(d)). Though clinics are at a higher health level than the health NGOs, 86.4%, of the clinics in the study area do refer cases to health NGOs (Table 3(e)). In the study area, it was observed that there is a poor relationship between hospitals, traditional healers and health NGOs. Though traditional healers, health NGOs and other health care levels do refer cases to the hospital in the study area, these hospitals, in-turn do not give feedback to the traditional healers and health NGOs. It can be concluded that in the study area there are no effective referral systems as the higher levels of health care usually ignore the potential of lower levels of health care units.

The highest levels of health care, like the hospitals in the study area, must receive cases; information from the lower levels of health care and at the same time higher levels must give feedback to the lower levels if P.H.C. is to be effective. Secondly it was observed that referrals in the study area are grossly incomplete. It should involve not only the exchange of information of the health situation of the study area, but also, technology and even personnel.

6.3.0: PROBLEMS AFFECTING THE REFERRAL SYSTEM

6.3.1: INTRODUCTION

It was observed that each of these levels has their own problems and these problems, to an extent, affect an effective referral system in the study area.

6.3.2: TRADITIONAL HEALERS

The major problem identified in the study area under this level is the fact that the traditional healers are not recognised by other health institutions. They are often regarded as witch doctors. According to one Mr. Ndebe, a traditional healer, he

claims that this problem stems from the fact that they are regarded as 'evil-doers' rather than traditional healers. As a result other health care units do not consider them as health care officers. Most of the traditional healers claim they are looked upon as out-casts of society, rather than being looked upon as care giver of society and protectors of the environment. Another problem faced by the traditional healers of the study area is the fact that, though they are trained by the government, the very same government ironically over-look them and rejects the very same certificates issued by the government. For example, it was observed in the study area, that most people ignored traditional healers because the medical certificates issued by the traditional healers are not recognised by most people, especially the government.

Another problem is the lack of facilities for the traditional healers. Infrastructure, such as ambulances, educational facilities as well as other medical facilities needs to be provided to these traditional healers to achieve effective referrals. Finally, the lack of communication between the traditional healers and other health care units have been observed to be a major hindrance affecting effective referral systems in the study area.

6.3.3:CLINICS AND COMMUNITY CENTRES

The major problem identified at this level of health care was the lack of health infrastructure. The lack of ambulances was a major problem in this study area. Effective referrals cannot be achieved because at this level patients need to wait for hours after phoning before an ambulance will arrive at the scene where there is a casualty or patients in need.

6.3.4:HEALTH NGOs

Like the clinics the health NGOs in the study area are also faced with the problem of infrastructure. It was observed that these NGOs lack adequate accommodation for their patients. This would however have been a good cause

for referral to other health institutions. The lack of transportation, which is a major requirement for health institutions, greatly affects effective referrals in the study area.

6.3.5: HOSPITALS

All the hospitals in the study area were identified to face the major problem of lack of infrastructure, such as ambulances and accommodation for their patients. Also it was observed that the lack of information about the lower levels, especially the NGOs and the traditional healers, affected the degree of referral amongst these health care units.

Generally, it was observed that lack of infrastructure, accommodation, low educational levels and the lack of government involvement and interventions such as the granting of subsidies, are the major problems which affect referral systems in the study area.

6.4: SUMMARY, CONCLUSIONS AND RECOMMANDATIONS

6.0.4:INTRODUCTION

This section will present the summary, conclusion and recommendations from my findings.

6.4.1: SUMMARY

The study assesses the effectiveness of referral systems in primary health care in the West Rand Region. It indicates that a referral system play an exceptionally important role in the preventive aspect of primary health care, with special reference to rural/urban areas.

Primary health care is the nucleus of a comprehensive health system supported by an effective referral system. The secondary and tertiary health services must be maintained in order to ensure proper support of primary health care. From this study, it is quite evident that primary health care demands maximum community involvement well informed responsible personnel, as well as individual participation. If one wishes to define referral systems it is important to look at the linkages more practically than theoretically, including the developments of new technology and technological procedure. Primary health care should also be involving the lower health care levels especially for feedback to achieve an effective referral system.

In terms of the Constitution of the Republic of South Africa, health is a fundamental human right, and the attainment of the highest possible level of health is most important nationwide. This task falls within the scope of community health workers, community doctors, primary health care nurses and environmental health officers. It was also observed that the role of traditional healers is also very crucial in achieving good health for all South Africans.

For the primary health care approach to be successful in South Africa, all professional health workers involved, as well as the association of traditional healers, will have to be co-ordinated to create an effective primary health care team. According to my findings, equitable, affordable, available, accessible and acceptable health care services are a requirement for an effective rendering of health services in South Africa. Above all this must be supported with cooperation amongst the different health institutions, as well as enjoying the benefits of government support.

6.4.2: RECOMMENDATIONS

In concluding this research it is necessary to suggest and recommend the following: First, to envisage on a normative level some solutions to set the

integration of traditional medicine into the primary health care system in South Africa.

- Higher health care levels should not ignore the lower levels, including traditional healers. What could be done is for the provincial health government and other health professionals to officially recognise and appreciate the role-played by traditional healers and to regard their duties as indispensable in the area. This is borne out by the observation that traditional healers dominate in number and therefore cover most parts of urban and rural areas in South Africa. Their role should not be overlooked.

- Lots of hard work still has to be done to make traditional healers realise what their role within P.H.C. is. Since most of them are not learned, they are not sure of their potential and do not realise the importance of their role as health care workers. Workshops should emphasize team approach, and must be conducted by the Department of National Health in the region. Emphasis should also be laid on referrals if effective health care is to be achieved.

- Health workers, for example, nurses, doctors, etc should not discourage the belief and activities of traditional healers. Instead they should work together, learn from each other and discourage or correct what is regarded as harmful ways of treating disease and replace them with better health care methods (Werner: 1979: 1-20).

- There should be a proper technical support for traditional medicine to promote further development and refinement of therapeutic procedures and substances. A major ethical dilemma in South Africa is the lack of the promotion of traditional medicine. Nyamwaya (1995) observed that if there are traditional medical procedures and substances, which can be used in the management of medical conditions, such, should be promoted for use by the general population. Failure to promote such procedures or substances goes against medical ethics, that is the principle of doing good, causing no harm,

and acknowledging the rights of patients to choose the kind of treatment they prefer.

- Secondly, traditional practitioners need support in terms of training in basic disease prevention and management skills as well as general technology. Such support could be offered through in-service training or pre-service courses.

- Thirdly, it is important for traditional medical practitioners in South Africa to operate within a clearly defined organizational framework. This framework is lacking in South Africa, with no government related structural arrangements to facilitate regulation of traditional medicine. Also, there are no clear guidelines for certification and registration. Though there are associations of traditional healers, they tend to cater only for those practitioners with a predisposition for publicity, mainly as a way of attracting clients. Nyamwaya (1995) has observed that publicity-shy practitioners have not joined the associations which is itself an expensive undertaking.

- It has been observed that lack of organizational structures and procedures makes it difficult to control malpractice among the traditional practitioners in South Africa. For example, patients are lured into paying large sums of money for cures related to incurable diseases such as cancer and AIDS. This lack of professional regulation on practice by traditional healers therefore leads to overcharging. Besides, there are not any generally accepted rates for the management of the same illness by different practitioners and such a situation facilitates the thriving of quacks in traditional medicine (Nyamwaya: 1995).

- Government legislation governing traditional medicine in South Africa needs to be clearly defined, with policies encouraging research in traditional

medicine in other to provide scientific basis for the types of drugs prescribed by traditional healers.

- The primary health certificate awarded to traditional healers by South Africa's Health Department should be recognised and made known to the community and employees so that medical certificates issued by traditional healers to their clients after consultation should be accepted and recognised, especially by employers.

- Individuals, institutions and health NGOs should be subsidized with infrastructure by the government to empower traditional healers and other health care institutions to effectively carry out their job.

- Traditional healers should be trained to recognise the signs and symptoms of diseases so that they can be able to refer patients to higher health care units. They should also be trained in first aid techniques.

- The lack of organizational structures and procedures of traditional healers in South Africa has resulted to many negative effects such as delayed referrals, the use of drugs with negative effects and poorly trained traditional practitioners. This situation has been the main reinforcer of the negative attitudes of administrators and western type of health workers towards traditional medicine and healers. There is great need for cooperation between traditional practitioners and modern practitioners, and it is quite possible in the South African context. In this light, neither party is required to change its approach to disease management or even the basic concepts of health and illness. This will however depend very much on South Africans and the various institutions, or practices they prefer in case of a need for health care.

- It should be conveyed with emphasis to the traditional healers that their contributions to health care and practices of referring patients to other health care institutions is crucial to primary health care for all South Africans.

- Considering the strategy for P.H.C. in SA and the expectations of other health professions (nurses) included in the study, it is clear that nurses are not well equipped and trained for their functions. The majority of nurses, for example, have attained standard 10 as the highest standard passed. Therefore it is important to provide in-service training for nurses and other health care workers.

6.4.3: CONCLUSION

The importance of an effective referral system, as seen through the responses of this research, cannot be over emphasized in the area of primary health care. In implementing the Health Care plan, the accessibility of resources and facilities in the community must be kept in mind. The community health nurses have the responsibility to help the family benefit from the services of the available community resources and to interpret and clarify the type and kind of services that are available.

Nurses, doctors as well as traditional healers don't have the competency to meet all the needs of the community and must constantly be aware of the opportunities for referral to other health institutions. Achieving an effective referral system involves determining the extent to which health care workers can alleviate problems in contrast to the possible contributions of other persons and resources. The health worker may decide whether rehabilitative NGOs services will meet his needs, whether a physical therapist is necessary or whether he should be referred to other health care institutions. The decisions of the health care worker will depend in part upon the community services that are available, but he must weigh all the alternatives as implemented in the Health Care Plan.

Additional information about community health workers' participation in community planning groups adds another dimension to ones understanding of health care in the community. The referral sources of individuals and families or groups to the community health nursing services provide some clues about the knowledge of community health. In turn the referral arrangements of community health care services with other facilities; gives some ideas about continuity and comprehensive health care. Some state departments have passed regulations that requires community health care workers or social workers to be employed or to take responsibility for planning and the continuity of health care before the patients are discharged from the hospital.

All health care services in a community must be looked at in order to have a composite picture of a good primary health care system. The community health leaders should take the leadership role in working with other health leaders to make the health care system responsive to the health needs of the community. In doing this, the potential of health contribution to the improvement of the health status of South African people will come nearer to fulfillment.

BIBLIOGRAPHY

Akerele, O., 1987: *The Best of Both Worlds: Bringing Traditional Medicine Up to Date.* Social Science and Medicine 24, No 2, pp. 177-181.

ANC 1994: *A National Health Plan for South* Africa. Department of Health, Johannesburg.

Baquar, S. R., 1995: The Role of Traditional Medicine in a Rural Environment. In I. Sindiga, C. Nyaigott-chacha, M. P. Kanuah (eds.), *Traditional Medicine in Africa.* East African Educational Publishers, Kenya.

Beauchamp, T. L. and Childress, J. F., 1989: *Principles of Biomedical Ethics*. Oxford University Press, New York.

Broomberg, J. and Shisana, O., 1995: *Restructuring the National Health System for Universal Primary Health Care.* A simplified version of the report of the committee of inquiry into a National Health Insurance System. Department of Health, Pretoria South Africa.

Chavunduka, G., 1978: *Traditional Healers and the Shona Patient.* Gwelo Mambo Press, Rhodesia.

Fry, J., 1978: *New Approach to Medicine: Principles and Priorities in Health Care.* University Park, Baltimore.

Fry, J., 1980: (ed) *Primary Care*. William Heineman, Medical Book Ltd: London.

Gambrill, E., 1980: Organisation of primary Health Care. In J. Fry (ed) *Primary Care*. William Heineman, Medical Book Ltd: London.

Gumede, M. V., 1990: *Traditional Healers a Medical Doctor's Perspective,* Skotaville Publishers, Braamfontein, Johannesburg.

Hart, R. H., Beksy, A. M., and Tarimo, E., 1990: *Integrated Material and Childhealth Service with Primary Health Care.*WHO, Geneva: Switzerland.

Hodgkings, K., 1978: *Towards Earlier Diagnosis in Primary Health Care.* Longman Inc: New York.

Johnstone, P., and Ranken, J., 1994: *Management Support for Primary Health Care*,.Lewenham Press Ltd: Suffolk, England.

Kathleen, D., King, L., Lock, M., Swanepoel, T., 1995: *Aspects of Primary Health.* Southern Book Publishers: Durban.

Kohn, R., and White, K. R., 1976: *Health Care. An International Study.* Oxford University Press: London.

Marcia, S., and Lancaster, J., 1992: *Community Health Nursing. Process of Practice for Promoting Health.* United State of America.

Mukhola, S. M., Mokgobu, M. I., Aucamp, A. J., 1989: *The Role of Environmental Health Officers in Primary Health Care*. Department of Health, Pretoria.

National Progressive Primary Health Care Network (NPPHC), 1998: *Manual for Implementing Health Rights in Communities,* Module 2: Draft 14. Department of Health, Braamfontein, South Africa.

Nyamwaya, D. O., 1995: The case for Traditional Medicine in Official Health Services: Flogging a Dead Horse? In I. Sindiga., C. Nyaigotti-Chacha., M. P.

Kanunah (eds.) *Traditional Medicine in Africa.* East African Educational Publishers, Kenya.

Schroder, P., 1986: *Tuberculosis and Traditional Medicine in Botswana.* Berlin Express Edition, Berlin.

Shaw, P. R., and Edward, A., 1993*: Better Health in Africa*. Technical working Paper No 7. Human Resources and Poverty Division, World Bank: Pretoria.

Sindiga, I., 1995: Traditional Medicine in Africa: An Introduction. In I. Sindiga , C. Nyaigotti-Chacha , and M. P. Kanunah , (eds.) *Traditional Medicine in Africa.* East African Educational Publishers, Kenya.

Staugard, F., 1985: *Traditional Medicine in Botswana. Traditional Healers.* Ipelegeng Publishers, Gaberones.

Stephen, J., 1980: Systems of Primary Health Care, in J. Fry, (ed*) Primary Care.* Heineman London.

Subcommittee on Primary Health Care, 1992**:** *Strategy for Primary Health Care in South Africa*. Department of Health, Johannesburg.

Swiderski, R. M., 1995: Confidence in traditional healers, in I. Sindiga., C. Nyaigotti-Chacha., M. P. Kanunah (eds.) *Traditional Medicine in Africa.* East Africa Educational Publishers, Kenya.

Sydney, L., Kark, M. D., 1980: *The Practice of Community Orientated Primary Health Care*. Prentice-Hall International Inc: London.

Wood, C. H., 1986: *Report of the International Workshop on* United Nation Children Fund and WHO: New York.

Vangham, J. H., and De Glanville H., 1993: *Community Health*. African Medical Research Foundation: Nairobi, Kenya.

Van Rensburg H.C.J., Fourie, A., Pretorius, E., 1992**:** *Health Care in South Africa: Structure and Dynamics.* Academia-Van Schaik: Pretoria.

Van Rooyen, D. J., 1994*: Environment Health Officer, Training Course.* Department of Health, Pretoria, South Africa.

Volk, M. E., 1990: *Manual of Community Health for Nurses.* The Rustica Press: Wynberg, Cape Town.

Werner, D., 1979: *Where There is No Doctor. A Village Health Care Handbook for America.* Macmillan Publishers: California.

APPENDIX I

The Effectiveness of Referral System in P.H.C. in the West Rand Region.

Instructions: *Please supply the relevant information required by filling in the blank spaces or a tick where necessary.*

SECTION A (Traditional healers)

1: Name of institution----------

2: Name of respondent----------

3: Sex of respondent----------

4: Age of respondent----------

5: Educational status of respondent--------a) Primary.....

b) Secondary.....

c) High school.....

d) Tertiary.....

e) Never been to school.....

6: Religious affiliation----------

7: What sort of cases do you receive?----------

8: How often do you receive patients?----------

9: Do you always treat your patients? Yes/No----------

10: If no to question 9 above, what advice do you give your patients?----------

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11: Have you ever had a case that you can not treat? ----------

12: If no what did you do? ----------

13: Have you ever referred cases to other institutions? ----------

14: If no why not? ----------

15: Have you ever received cases from other institutions? ----------

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16: If yes to question 15 above which institutions? ----------

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17: Did you successfully treat the case? ----------

18: Did you give feedback from the institution where the case came from? ---------

19: If yes how? ----------

20: If no, why not? ----------

21: What relationship(s) do your institutions have with other health institutions? --

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22: What problems do you have with other health institutions? ----------

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23: How do you solve these problems? ----------

24: How useful are other health institutions to you?----------

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25: What other problems are affecting your health institution? ----------

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SECTION B (Health NGO)

1: Name of health NGO----------

2: Name of respondent----------

3: Position of respondent----------

4: Age of respondent----------

5: Sex of respondent----------

6: Religious affiliation----------

7: Educational status----------

8: What sort of cases do you receive? ----------

9: How often do you receive patients? ----------

10: Do you always treat your patients?----------

11: If no to question 10 above, what advice do you give the patients? ----------

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12: Have you ever had a case that you can not treat? ----------

13: If no, what did you do? ----------

14: Have you ever referred cases to other institutions?----------

15: If no why not? ----------

16: Have you ever-received cases from other institutions? ----------

17: If yes to question 16 above which institutions? ----------

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18: Did you successfully treat the case? ----------

19: Did you give feedback to the institution where the case came from? ----------

20: Have you ever referred cases to traditional healers? ----------

21: If no, why not? ----------

22: If yes did you get feedback from the traditional healer? ----------

23: Have you ever had the same case repeating itself? ----------

SECTION C (Clinics)

1: Name of clinic----------

2: Name of respondent----------

3: Position of respondent----------

4: Age of respondent----------

5: Sex of respondent----------

6: Religious affiliation of respondent----------

7: Educational status of respondent----------

8: What sort of cases do you receive? ----------

9: How often do you receive patients? ----------

10: Do you always treat your patients? ----------

11: If no to question 10 above what do you advise your patients to do? ----------

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12: Have you ever had a case that you can treat? ----------

13: If no what did you do? ----------

14: Have you ever referred cases to other institutions? ----------

15: If no, why not? ----------

16: Have you ever received cases from other institutions? ----------

17: If yes to question 16 above which institutions? ----------

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18: Did you successfully treat the case? ----------

19: Did you give feedback to the institution where the case came from? ----------

20: Have you ever referred cases to traditional healers? ----------

21: If no, why not? ----------

22: If yes did you get feedback from the traditional healers? ----------

23: Have you ever had the same case repeating itself? ----------

24: Have you ever referred cases to health NGOs? ----------

25: If no, why not? ----------

26: If yes, did you get feedback? ----------

SECTION D (HOSPITALS)

1: Name of hospital----------

2: Name of respondent----------

3: Position of respondent----------

4: Age of respondent----------

5: Sex of respondent----------

6: Religious affiliation of respondent----------

7: Educational status of respondent----------

8: What sort of cases do you receive? ----------

9: How often do you receive patients? ----------

10: Do you always treat your patients? ----------

11: If no to question 10 above, what do you advise your patients to do? ----------

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12: Have you ever had a case that you cannot treat? ----------

13: If no what did you do? ----------

14: Have you ever referred cases to other institutions? ----------

15: If no, why not? ----------

16: Have you ever receive cases from other institutions? ----------

17: If yes, to question 16 above, which institutions? ----------

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18: Did you successfully treat the case? ----------

19: Did you give feedback to the institution where the case came from? ----------

20: Have you ever referred cases to traditional healers? ----------

21: If no why not? ----------

22: If yes, did you get feedback from the traditional healers? ----------

23: Have you ever had the same case repeating itself? ----------

24: Have you ever refer cases to health NGOs? ----------

25: If no, why not? ----------

26: If yes, did you get feedback? ----------

27: Have ever referred cases to the clinics? ----------

28: If no, why not? ----------

29: If yes, did you get feedback? ----------

30: Do you give feedback to other health institutions? ----------

31: If no, why not? ----------

32: If yes, how often and which institutions----------
